ANNUAL MEDICAL PAYMENT REPORT

Michigan Department of Labor & Economic Growth
Workers' Compensation Agency
Health Care Services Division
P.O. Box 30016, Lansing, MI 48909

ANNUAL REPORTING PERIOD: 1/01/___ to 12/31/___
(Due by February 28th the Year Following the Reporting Period)

I. CARRIER INFORMATION

Carrier Name (Insurance Co., Self-Insured, or Fund)	NAIC or Self-Insured No.
Address (number & street)	Telephone No. (include area code)
City, State, Zip Code	Carrier Contact Person
Service Co. Submitting Information for Self-Insured/Self-Administered	Service Co. Contact Person & Telephone No. (include area code)

II. ANNUAL MEDICAL PAYMENT REPORT

Include data for payment of all medical expenditures.

Do not include payments for the following:

a. Indemnity payments
b. Mileage reimbursement
c. Vocational rehabilitation or medical case management expenses
d. Independent medical examinations or legal expenses

CASE TYPE	NUMBER OF CASES	TOTAL DOLLARS SPENT FOR MEDICAL CARE
Medical Only		$
Wage Loss		$

By signing this form, I certify that the information included in this annual medical payment report and accompanying attachments, if any, is true, correct and complete to the best of my knowledge.

Authorized Signature	Authorized Name (typed or printed)	Date

The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.	Authority: Workers' Compensation Health Care Services Rules, part 14, R418.101401 Completion: Mandatory. Must be completed and submitted to the agency by 2/28 annually for the previous year. Penalty: Failure to provide data shall prevent certification of the Carrier's Professional Health Care Review Program pursuant to part 12, R418.101206